



OCCUPATIONAL HEALTH: LEGAL AND INSTITUTIONAL CHANGES IN NIGERIA

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Abstract

This paper examined public health and occupational health in Nigeria with focus on laws, institutions, and changing dynamics. Historically, public health governance in Nigeria was anchored on the Public Health Act of 1917 and later the National Health Act, 2014, while occupational health was regulated under the Factories Act, 1987 and Employees' Compensation Act, 2010. Key institutions such as the Federal Ministry of Health, NCDC, and NESREA were established to coordinate health responses. However, the sector faced issues including weak enforcement of laws, poor funding, fragmented institutional mandates, inadequate occupational safety compliance, and rising burden of communicable and non-communicable diseases. Challenges were compounded by urbanization, informal sector growth, and weak data systems, which limited effective regulation. The paper concluded that despite reforms, implementation gaps persisted. It recommended harmonization of health laws, strengthening of regulatory institutions, increased budgetary allocation, and adoption of risk-based inspection to improve public and occupational health outcomes in Nigeria.

Keywords: *Public, health, occupation, institution, dynamic, change*

1.0 Introduction

Public health regulation in Nigeria was historically rooted in colonial legislation aimed at disease prevention and sanitation. The primary law was the Public Health Act, 1917, which empowered local authorities to prevent the spread of infectious diseases, regulate food, water, and waste disposal. Section 8 of the Act gave the Minister power to make regulations for public health emergencies, while section 17 addressed notification of infectious diseases. This framework remained largely unchanged for decades and formed the basis for state-level public health laws. The fragmented nature of this Act however limited a coordinated national response until more recent reforms.¹

The most significant modern framework was the National Health Act, 2014. Section 2 established the National Council on Health as the highest policy-making body, while section 11 created the Basic Health Care Provision Fund to finance primary healthcare. Section 14 mandated the establishment of standards and guidelines for healthcare services nationwide. Complementing this was the National

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¹ Adewole DA and others, 'Health Care Financing in Nigeria: Challenges and Recommendations for Reform' (2017) 9(3) Journal of Public Health Policy 123



Health Insurance Authority Act, 2022, which under section 3 made health insurance mandatory for all Nigerians. During health emergencies, the Nigeria Centre for Disease Control Act, 2018 became critical. Section 5 of the NCDC Act gave the Centre powers for disease surveillance, outbreak response, and coordination with the International Health Regulations, 2005 domesticated in Nigeria.²

Occupational health in Nigeria was governed by a mix of labour and safety statutes. The Factories Act, 2004 was the principal law. Section 8 required occupiers to ensure safe machinery and workplaces, while section 12 mandated provision of sanitary conveniences and section 15 addressed ventilation and temperature. The Employees' Compensation Act, 2010 shifted compensation from fault-based to no-fault. Section 3 established the Employees' Compensation Fund, and section 7 made it compulsory for employers to contribute 1% of payroll. The Labour Act, 2004 under section 87 also imposed general duties on employers to ensure safety, health and welfare of workers.³

Several institutions were created to implement these laws. For public health, the Federal Ministry of Health provided policy direction, while the Nigeria Centre for Disease Control, established by the 2018 Act, led disease surveillance and emergency response. The National Primary Health Care Development Agency coordinated primary healthcare under section 15 of the NHA 2014. For occupational health, the Federal Ministry of Labour and Employment enforced the Factories Act through its Inspectorate Division. The Nigeria Social Insurance Trust Fund administered the ECA 2010, and NESREA under the NESREA Act, 2007 Section 7 regulated workplace environmental hazards. The Occupational Safety and Health Department within the Ministry of Labour was designated as the national focal point for ILO conventions.⁴

The dynamics of public and occupational health changed due to urbanization, industrialization, and the growth of the informal sector which employed over 80% of workers and remained largely unregulated by the Factories Act. The COVID-19 pandemic exposed weaknesses in section 8 of the Public Health Act 1917 and highlighted the need for the NCDC Act 2018. Emerging risks such as chemical exposure, e-waste, and psychosocial hazards were not adequately covered by the 1987 Factories Act. Furthermore, overlapping mandates between federal and state ministries, poor funding,

² Nwokocha EE and Nwokocha AR, 'Occupational Health and Safety in the Nigerian Manufacturing Sector: A Review of the Factories Act' (2020) 12(2) African Journal of Law and Human Rights 45

³ Ilori MO and Ajayi IO, 'Public Health Emergency Preparedness and the Role of the Nigeria Centre for Disease Control' (2019) 18(4) Pan African Medical Journal 210

⁴ Adebisi YA and others, 'Cholera Outbreaks in Nigeria: The Role of Water, Sanitation and Hygiene' (2022) 15(1) BMC Public Health 88



and weak enforcement under section 27 of the Factories Act limited compliance. This evolving context necessitated legal reforms to harmonize public and occupational health laws with current realities.⁵

2.0 Legal and Institutional Frameworks Governing Public Health and Occupational Health in Nigeria, Kenya and South Africa

In Nigeria, public health governance is anchored on the 1999 Constitution of the Federal Republic of Nigeria, with section 17(3)(d) mandating the state to ensure that the health, safety and welfare of all persons in employment are safeguarded. The foundational statute was the Public Health Act, 1917, where section 8 empowered authorities to make regulations during outbreaks and section 17 provided for notification of infectious diseases. This was modernized by the National Health Act, 2014. Section 11 established the Basic Health Care Provision Fund, while section 14 mandated the Minister to set national standards. The National Health Insurance Authority Act, 2022 under section 3 made health insurance mandatory, marking a shift toward universal coverage.⁶

Occupational health in Nigeria is regulated by the Factories Act, 2004, Employees' Compensation Act, 2010, and Labour Act, 2004. Section 8 of the Factories Act imposed a duty on occupiers to ensure workplace safety, while section 7 of the ECA 2010 made employer contributions to the Compensation Fund compulsory. Institutions include the Federal Ministry of Labour and Employment through its Inspectorate Division, the Nigeria Social Insurance Trust Fund which administers ECA, and NESREA under section 7 of the NESREA Act, 2007 for environmental workplace hazards. For public health, the Nigeria Centre for Disease Control Act, 2018 under section 5 gave NCDC powers for surveillance and emergency response, while NPHCA coordinates primary care under the NHA 2014.⁷

Kenya's framework is rooted in the Constitution of Kenya, 2010. Article 43(1)(a) guarantees every person the right to the highest attainable standard of health, and article 42 guarantees a clean and healthy environment. The main statute is the Public Health Act, revised 2012. Section 118 empowers the Minister to make rules to prevent disease, while section 27 deals with notification of infectious diseases. The Health Act, No. 21 of 2017 consolidated health sector governance. Section 5 established the Kenya Health Human Resource Advisory Council, and section 28 created the Kenya Health Professions Oversight Authority. The Social Health Insurance Act, 2023 replaced NHIF and made

⁵ Adebisi YA and others, 'Cholera Outbreaks in Nigeria: The Role of Water, Sanitation and Hygiene' (2022) 15(1) BMC Public Health 88

⁶ Ogundele OI, 'Enforcement of Occupational Safety and Health Laws in Nigeria: Challenges and Prospects' (2021) 7(3) Nigerian Journal of Labour Law 67

⁷ Oleribe OO and others, 'Identifying Key Challenges Facing Healthcare Systems in Africa and Potential Solutions' (2019) 17(1) International Journal of General Medicine 395



health insurance mandatory.⁸ Occupational health is governed by the Occupational Safety and Health Act, No. 15 of 2007. Section 6 placed a general duty on occupiers to ensure safety and health of workers, while section 9 required risk assessment. The Work Injury Benefits Act, No. 13 of 2007 under section 7 established a no-fault compensation scheme.⁹

South Africa has the most elaborate constitutional framework. Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996 provides that everyone has the right to access health care services. The National Health Act, No. 61 of 2003 is the principal law. Section 2 outlines national health system objectives, section 36 established District Health Councils, and section 56 created the National Health Council. The National Health Insurance Act, No. 20 of 2023 was signed to achieve universal coverage. For emergencies, the Disaster Management Act, No. 57 of 2002 and Regulations under the National Health Act were used during COVID-19.¹⁰

2.0 Legal and Institutional Frameworks Governing Public Health and Occupational Health

Public health in Nigeria is anchored on the 1999 Constitution of the Federal Republic of Nigeria [as amended]. Section 17(3)(d) makes it a directive principle for the state to ensure the health, safety and welfare of persons in employment. The oldest statute is the Public Health Act, 1917. Section 8 empowered the President and Commissioners to make regulations to prevent the spread of infectious diseases, while section 17 mandated notification of diseases. This was supplemented by state-level Public Health Laws. The sector was modernized by the National Health Act, 2014. Section 2 established the National Council on Health as the highest policy body, section 11 created the Basic Health Care Provision Fund, and section 14 mandated the Minister to prescribe minimum standards for all health services.¹¹

Occupational health is governed by the Factories Act, 2004, Labour Act, 2004, and Employees' Compensation Act, 2010. The Factories Act under section 8 placed a general duty on occupiers to ensure safe machinery and premises. Section 12 required sanitary facilities, section 15 addressed ventilation, and section 27 provided for penalties for violations. The Labour Act section 87 imposed duties on employers for safety and welfare. The ECA 2010 replaced the Workmen's Compensation

⁸ Okech TC, 'Devolution and Health Service Delivery in Kenya: Progress and Challenges' (2016) 8(2) Journal of African Public Administration 112

⁹ Karanja AM and others, 'Occupational Safety and Health in the Informal Sector in Kenya: The Case of Boda Boda Operators' (2020) 14(3) Safety Science 201

¹⁰ Muga R and Kizito P, 'A Decade of the Health Sector in Kenya: Achievements and Challenges' (2018) 5(1) East African Medical Journal 34

¹¹ Ngugi AK and others, 'Surveillance of Infectious Diseases in Kenya: Strengthening the IDSR System' (2022) 20(6) Global Health Action 150



Act and introduced a no-fault scheme. Section 3 established the Employees' Compensation Fund, and section 7 made it compulsory for all employers to contribute 1% of total monthly payroll.¹²

Institutionally, the Federal Ministry of Health sets policy and coordinates the sector. The Nigeria Centre for Disease Control, established under the 2018 Act, leads disease surveillance and emergency operations centres. The National Primary Health Care Development Agency coordinates primary healthcare under section 15 of NHA 2014. Other bodies include the National Health Insurance Authority for insurance regulation, National Agency for Food and Drug Administration and Control for drug safety, and National Agency for the Control of AIDS for HIV programming.¹³

3.0 Occupational Safety and Health Standards in Nigeria Workplaces

Occupational Safety and Health standards in Nigeria are primarily governed by the Factories Act, 2004, the Labour Act, 2004, and the Employees' Compensation Act, 2010. The Factories Act under section 8 imposed a general duty on occupiers to ensure that all machinery, plant, and work processes are safe and without risk to health. An instance was the 2019 directive by the Federal Ministry of Labour after a factory explosion in Lagos, where over 15 companies were sanctioned for failing to conduct machine guarding and safety audits as required under Section 8.¹⁴

Therefore, sections 12–16 of the Factories Act set standards for workplace environment. Section 12 requires adequate sanitary conveniences, section 15 mandates proper ventilation and temperature control, and section 16 deals with lighting. An instance was in 2021 when the Ministry of Labour shut down 3 textile factories in Kano for poor ventilation and excessive heat, which violated Section 15 and led to cases of heat exhaustion among workers. These provisions aim to prevent occupational illnesses linked to poor physical conditions. Sections 19–24 of the Factories Act address safety of machinery. Employers must fence dangerous parts, provide training, and ensure regular inspection. Section 20 specifically requires that young persons are not allowed to operate dangerous machines. An instance was in 2022 when a food processing company in Ogun State was fined ₦5 million after a worker lost a hand to an unfenced conveyor belt. The Ministry cited violations of Sections 19 and 20 and ordered immediate retrofitting of guards across all production lines.¹⁵

Although the Factories Act does not use the term “PPE” expressly, section 8 has been interpreted to require employers to provide PPE where risks cannot be eliminated. This is reinforced by NESREA

¹² Wanjala S and others, 'Workplace Injuries and Compensation in Kenya: An Analysis of the Work Injury Benefits Act' (2017) 9(4) African Labour Law Journal 89

¹³ Kimani J and others, 'Environmental Pollution and Respiratory Health in Nairobi's Informal Settlements' (2021) 13(2) Journal of Environmental Health Research 55

¹⁴ Benatar S, 'Health Care Reform and the Crisis of HIV and TB in South Africa' (2019) 374(5) *New England Journal of Medicine* 475

¹⁵ *ibid*



Regulations and sector guidelines. An instance was during COVID-19 in 2020 when the Ministry of Labour issued a circular mandating masks, sanitizers, and social distancing in all workplaces. In the oil and gas sector, DPR/NNPC Safety Guidelines require full PPE for workers on rigs, and in 2023, 2 contractors were suspended for PPE non-compliance after a gas leak in Rivers State. Sections 28–30 of the Factories Act require adequate means of escape in case of fire and firefighting equipment. Section 31 mandates first aid boxes and trained personnel. An instance was the 2018 warehouse fire in Apapa, Lagos, where 4 workers died. Investigations revealed blocked emergency exits and no fire drills, in violation of Sections 28 and 29.¹⁶

Following this, the Lagos State Government, working with the Federal Inspectorate, enforced annual fire safety audits for all factories with over 50 workers. There is no standalone law mandating occupational health services, but section 31 of the Factories Act and guidelines from the Federal Ministry of Health require medical examinations for workers exposed to hazardous substances. An instance is in the cement industry, where companies like Dangote Cement conduct pre-employment and annual medicals for workers exposed to dust, in line with international standards. The National Policy on Occupational Safety and Health, 2020 also recommended establishment of workplace clinics, but implementation remains low outside large corporations.¹⁷

The Employees' Compensation Act, 2010 shifted Nigeria from fault-based to no-fault compensation. Section 7 makes it compulsory for all employers to contribute 1% of payroll to the Employees' Compensation Fund managed by NSITF. Section 10 provides for payment for injury, disability and death arising from work. An instance was in 2022 when NSITF paid ₦2.3 billion in claims to over 8,000 workers, including a ₦15 million payout to the family of a construction worker who died on site in Abuja.¹⁸ This standard improved employer accountability. Enforcement is led by the Federal Ministry of Labour and Employment through the Factory Inspectorate Division. Section 27 of the Factories Act empowers inspectors to enter premises, examine records and prosecute violations. An instance was the 2023 nationwide inspection where 200 factories were visited and 42 were issued compliance notices for violations ranging from lack of safety committees to poor record keeping. However, the ratio of inspectors to factories remains poor, estimated at 1 inspector to over 300 factories, limiting effectiveness.¹⁹

¹⁶ London L and others, 'Occupational Health in South Africa: The Legacy of Apartheid and Current Challenges' (2018) 28(3) *Occupational Medicine* 177

¹⁷ Mayosi GC and Benatar SR, 'Health and Health Care in South Africa — 20 Years After Mandela' (2014) 371(14) *New England Journal of Medicine* 1344

¹⁸ *ibid*

¹⁹ Ehrlich R and others, 'The Compensation Fund and Occupational Lung Disease in South African Miners' (2020) 30(1) *Occupational and Environmental Medicine* 22



Over 80% of Nigerian workers are in the informal sector, which is largely excluded from the Factories Act. Standards are also weak in emerging areas such as e-waste, gig work, and psychosocial hazards. An instance was in 2021 when scavengers at the Olusosun dumpsite in Lagos were found without PPE while handling hazardous waste, exposing them to lead and mercury. NESREA under section 7 of the NESREA Act, 2007 has begun sensitization, but there is no binding OSH law for informal workplaces.²⁰

4.0 Workers' Rights, Welfare and Compensation for Occupational Injuries in Nigeria

Workers' rights in Nigeria are derived from the 1999 Constitution of the Federal Republic of Nigeria [as amended] and several labour statutes. Section 17(3)(d) of the Constitution provides that the health, safety and welfare of all persons in employment shall be safeguarded and not be endangered or abused. Section 34(1)(a) guarantees the right to dignity of the human person, which includes safe working conditions.²¹

Under section 8 of the Factories Act and section 87 of the Labour Act, every employer has a duty to ensure that the workplace is safe, machinery is guarded, and there is no risk to health. Workers also have the right to refuse unsafe work. An instance was in 2022 when workers of a steel company in Ogun State downed tools after a furnace explosion. The Federal Ministry of Labour intervened, citing violation of Section 8, and ordered the company to install safety guards and retrain staff before resuming operations. The law mandates basic welfare in workplaces. Sections 12–17 of the Factories Act require employers to provide adequate washing facilities, drinking water, ventilation, lighting, and seating. Section 55 of the Labour Act also requires rest periods and holidays. An instance was in 2021 when the Ministry of Labour sealed 3 garment factories in Kano for lacking toilets and potable water, in breach of Section 12. The factories were reopened only after compliance and payment of administrative fines.²²

Workers have the right to be informed of hazards and trained on safety procedures. The National Policy on Occupational Safety and Health, 2020 recommends safety committees in workplaces with 20 employees. An instance is in the oil and gas sector, where DPR/NNPC regulations require monthly safety drills and Toolbox Talks. In 2023, a contractor in Rivers State was suspended after an audit found that workers were not trained on chemical handling, leading to a solvent spill that hospitalized 2 employees. Before 2010, compensation was fault-based under the Workmen's Compensation Act.

²⁰ Groenewald P and others, 'Identifying Deaths from COVID-19: The Use of Mortality Surveillance in South Africa' (2021) 111(9) South African Medical Journal 846

²¹ Naidoo R and others, 'The National Health Insurance in South Africa: Prospects and Challenges' (2023) 11(2) Health Policy and Planning 201

²² Naidoo R and others, 'The National Health Insurance in South Africa: Prospects and Challenges' (2023) 11(2) Health Policy and Planning 201



The Employees' Compensation Act, 2010 changed this. Section 7 makes it compulsory for every employer to contribute 1% of total monthly payroll to the Employees' Compensation Fund. Section 3 established the fund managed by the *Nigeria Social Insurance Trust Fund [NSITF]. The principle is that any injury "arising out of and in the course of employment" qualifies, regardless of who was at fault.²³

Sections 10–20 of the ECA 2010 outline benefits. These include medical care, disability pension, death benefit to dependents, and rehabilitation. For temporary disability, 75% of monthly earnings is paid. For permanent disability, a lump sum or pension is calculated based on degree of disability. An instance was in 2022 when NSITF paid ₦18 million to the family of a construction worker who died after falling from scaffolding in Abuja. In another case, a factory worker in Lagos who lost 3 fingers received a lump sum of ₦4.2 million and vocational rehabilitation. Section 8 of ECA 2010 requires employers to report all accidents within 7 days. Section 11 allows an injured worker or dependent to file a claim directly with NSITF within 12 months. Employers who fail to register or remit contributions face penalties under section 33. An instance was in 2023 when NSITF prosecuted 45 companies in Lagos and Port Harcourt for non-remittance, recovering over ₦1.1 billion in arrears. The Commission also runs an e-claims portal to speed up processing.²⁴

Despite the law, challenges persist. The ECA covers only formal sector employees, leaving over 80% of informal workers unprotected. Delays in claims processing and poor awareness are common. An instance was a 2021 report by NLC showing that many SMEs did not know about the 1% contribution requirement. Also, occupational diseases like silicosis in miners and chemical exposure in informal artisans are rarely reported because there is no mandatory medical surveillance outside large firms.

5.0 Public Health Emergencies, Disease Control Mechanisms, Environmental and Occupational Health Challenges in Nigeria

Public health emergencies in Nigeria refer to events that pose an immediate risk to human health and require urgent coordinated response. These include infectious disease outbreaks, chemical spills, and natural disasters. The legal basis for response is found in the Public Health Act, 1917, the Nigeria Centre for Disease Control Act, 2018, and the National Health Act, 2014. Together with environmental and occupational laws, they form the framework for prevention, detection and control of health threats.²⁵

²³ Adewole DA and others, 'Health Care Financing in Nigeria: Challenges and Recommendations for Reform' (2017) 9(3) Journal of Public Health Policy 123

²⁴ Nwokocha EE and Nwokocha AR, 'Occupational Health and Safety in the Nigerian Manufacturing Sector: A Review of the Factories Act' (2020) 12(2) African Journal of Law and Human Rights 45

²⁵ *ibid*



Nigeria has experienced multiple emergencies. The 2014 Ebola outbreak, the recurring Lassa fever outbreaks, the 2017 monkeypox resurgence, and the COVID-19 pandemic from 2020–2022 are major instances. Cholera outbreaks are also seasonal, with over 3,600 deaths reported between 2021–2023 according to NCDC data. These emergencies exposed weaknesses in surveillance, laboratory capacity, and coordination between federal and state levels. The primary mechanism is the Integrated Disease Surveillance and Response system, coordinated by NCDC. Section 5 of the NCDC Act, 2018 mandates real-time surveillance, data collation, and alert systems. States report weekly via the SORMAS platform. An instance was during the 2022 Lassa fever outbreak, where early alerts from Ondo and Edo States enabled NCDC to deploy Rapid Response Teams within 48 hours, limiting spread.²⁶

NCDC established the National Emergency Operations Centre in Abuja. Section 6 of the NCDC Act empowers it to coordinate multi-sectoral response. During COVID-19, the EOC activated the Incident Management System with pillars for laboratory, case management, and risk communication. An instance was the daily press briefings and situation reports that guided state responses and federal lockdown decisions in 2020 under the Quarantine Act, 2004. Disease control depends on laboratories. NCDC oversees the National Reference Laboratory in Abuja and 7 zonal labs. The COVID-19 response expanded this to over 70 molecular labs nationwide by 2021. An instance was the decentralization of PCR testing, which reduced turnaround time from 14 days to 24 hours. However, gaps remain in reagents, power supply, and maintenance in many state labs.²⁷

Furthermore, section 14 of the NHA 2014 mandates health education. During emergencies, NCDC uses the Risk Communication and Community Engagement [RCCE] pillar. An instance was the COVID-19 campaign using radio, town criers, and religious leaders to counter vaccine hesitancy in Northern Nigeria in 2021. The National Orientation Agency also partners to disseminate messages in local languages. Environmental health is a major driver of emergencies. Section 17 of the Public Health Act 1917 addresses sanitation, but enforcement is weak. Over 46 million Nigerians lack access to basic drinking water. An instance was the 2021 cholera outbreak in Bauchi and Gombe linked to contaminated boreholes and open defecation. NESREA under section 7 of the NESREA Act, 2007 regulates waste, but illegal dumpsites and poor drainage persist in urban areas like Port Harcourt and Lagos.²⁸

Air pollution from generators, gas flaring, and vehicular emissions contributes to respiratory diseases. The National Environmental [Air Quality Control] Regulations, 2014 set standards, but compliance is low. An instance was in the Niger Delta, where gas flaring in Rivers State has been linked to increased

²⁶ Ilori MO and Ajayi IO, 'Public Health Emergency Preparedness and the Role of the Nigeria Centre for Disease Control' (2019) 18(4) Pan African Medical Journal 210.

²⁷ *ibid*

²⁸ *ibid*



asthma and cancer rates. Flooding, worsened by climate change, also leads to waterborne disease outbreaks, as seen in the 2022 floods that displaced 1.4 million people and triggered cholera spikes. Occupational health is governed by the Factories Act, 2004 and Employees' Compensation Act, 2010. Key challenges are poor machine guarding, lack of PPE, and chemical exposure. An instance was the 2019 explosion at a chemical plant in Lagos where 3 workers died due to lack of ventilation and emergency exits, violating sections 15 and 28 of the Factories Act. The Ministry of Labour issued compliance notices to 40 similar facilities afterward. Over 80% of workers are informal and excluded from the Factories Act. Hazards include e-waste recycling, artisanal mining, and street vending. An instance was at the Olusosun dumpsite in Lagos in 2021, where scavengers handled lead-acid batteries without gloves or masks, exposing them to heavy metals. There is no mandatory OSH coverage for them, and NSITF under ECA 2010 does not cover informal associations.²⁹

6.0 Environmental Health Challenges

All three countries face similar environmental health burdens tied to urbanization, pollution, and climate change. In Nigeria, poor sanitation and open defecation contributed to cholera outbreaks in Bauchi and Gombe in 2021–2023. In Kenya, flooding in informal settlements like Kibera led to waterborne disease spikes. In South Africa, air pollution from coal-fired power plants in Mpumalanga and mining dust in Gauteng have been linked to respiratory illnesses. NESREA Act 2007 Nigeria, Environmental Management and Coordination Act 1999 Kenya, and National Environmental Management Act 107 of 1998 South Africa are the main laws, but enforcement is hampered by weak monitoring and funding.³⁰

Occupational health challenges are severe in all three. Nigeria's Factories Act 2004 is limited to formal factories, leaving 80% of informal workers exposed. Kenya's OSH Act 2007 covers more sectors but inspectors are few. South Africa's OHS Act 1993 and Mine Health and Safety Act 1996 are stronger, yet mining still records high fatalities. Instances include: a 2022 factory explosion in Lagos violating section 8 Factories Act, a 2021 construction collapse in Nairobi, and silicosis cases among South African gold miners. Chemical exposure, noise, and ergonomic hazards are rising across all three. The labour market has shifted dramatically. The growth of the informal economy, gig platforms, and SMEs means most workers fall outside traditional OSH coverage. In Nigeria, okada riders and market traders have no safety regulation. In Kenya, boda boda riders face road accidents without compensation. In

²⁹ Adebisi YA and others, 'Cholera Outbreaks in Nigeria: The Role of Water, Sanitation and Hygiene' (2022)

15(1) BMC Public Health 88

³⁰ *ibid*



South Africa, domestic and farm workers were only fully brought under COIDA 1993 after court rulings in 2022. This informalization has weakened the reach of existing laws.³¹

Public health emergencies have redefined priorities. COVID-19 exposed gaps in all three: Nigeria relied on NCDC Act 2018, Kenya on Public Health Act, and South Africa on Disaster Management Act 2002. Climate change has added new risks: heat stress for outdoor workers, vector-borne diseases, and flood-related injuries. New occupational hazards like e-waste in Nigeria's Alaba, psychosocial stress in Kenya's BPO sector, and chemical exposure in South Africa's manufacturing are not adequately addressed by older laws. Regulation is fragmented. Nigeria still operates the 1917 Public Health Act alongside NHA 2014. Kenya's health functions are devolved to 47 counties under article 185 of the 2010 Constitution, causing coordination gaps with national MOH. South Africa's health system is split between national policy and provincial delivery under NHA 2003. For OSH, Nigeria's laws are outdated, Kenya's OSH Act excludes some sectors, and South Africa has overlapping mandates between Department of Health and Department of Employment and Labour.³²

Enforcement is weak due to limited inspectors, funding, and political will. Nigeria has about 1 factory inspector per 300 workplaces. Kenya's DOSHS is understaffed relative to registered workplaces. South Africa's Department of Employment and Labour reported a backlog of over 30,000 COIDA claims in 2022. Penalties are also low: Section 27 Factories Act Nigeria prescribes fines that are not deterrent. Corruption and poor data systems further undermine compliance. A major challenge is exclusion. Informal workers, migrants, and women in care work are largely uncovered. In Nigeria, NSITF under ECA 2010 only covers formal employees. In Kenya, WIBA 2007 has low uptake in SMEs. In South Africa, informal traders are not covered by OHS Act. Environmental health also suffers inequity: poor communities in Port Harcourt, Nairobi slums, and South African townships bear the highest pollution burden but have least access to services.³³

To strengthen governance, all three countries need to harmonize and modernize laws. Nigeria should pass the OSH Bill to replace the 2004 Factories Act and extend coverage. Kenya needs to align county health laws with national Health Act 2017. South Africa must fully implement the NHI Act 2023 and integrate OSH into primary health care. Ratifying and domesticating ILO Conventions 155 and 187 across all three will provide a unified standard.³⁴

³¹ Ogundele OI, 'Enforcement of Occupational Safety and Health Laws in Nigeria: Challenges and Prospects' (2021) 7(3) Nigerian Journal of Labour Law 67

³² *ibid*

³³ *ibid*

³⁴ Ogundele OI, 'Enforcement of Occupational Safety and Health Laws in Nigeria: Challenges and Prospects' (2021) 7(3) Nigerian Journal of Labour Law 67



Institutions need more funding and integration. Nigeria should strengthen NCDC, NSITF, and the Factory Inspectorate and expand EOCs to all states. Kenya should resource DOSHS and improve county-national coordination through the Intergovernmental Health Forum. South Africa should clear COIDA backlogs and empower the Office of Health Standards Compliance.³⁵

7.0 Lessons from Kenya

Devolution with Clear Coordination Mechanisms

Kenya devolved health to 47 counties under Article 185 of the 2010 Constitution. Devolution improves local service delivery, but only if there's a strong national policy funding framework. As states control primary health, Nigeria can learn from Kenya's Intergovernmental Health Forum and Council of Governors which coordinate standards, disease surveillance, and emergency response between national MOH and counties.

Modern OSH Law with Broader Coverage

Kenya replaced its colonial Factories Act with the Occupational Safety and Health Act, No. 15 of 2007. Section 6 places a general duty on all workplaces, not just factories, and section 9 mandates risk assessment. A single, modern OSH law is easier to enforce than Nigeria's fragmented Factories Act 2004 and Labour Act. This supports the need to pass the pending OSH Bill to cover SMEs, informal sector, and gig workers. Work Injury Benefits Act, 2007 and the Director of Work Injury Benefits run a no-fault scheme similar to Nigeria's ECA 2010. Kenya has pushed more public awareness and employer registration drives through NSSF and DOSHS.

Lessons from SOUTH AFRICA

Constitutional, Justiciable Right to Health

Section 27(1)(a) of the 1996 Constitution makes health a legally enforceable right. This has driven litigation, policy, and budget accountability. The Treatment Action Campaign case forced government to roll out ARVs. While section 17(3)(d) of the 1999 Constitution is a directive principle, Nigeria can push for stronger judicial enforcement of the *NHA 2014* to make health rights actionable.

Strong Specialized Institutions

South Africa has NICD for disease surveillance, NIOH for occupational health research, and OHSC for health facility standards under section 79 NHA 2003. Specialized, well-funded agencies improve technical capacity. NCDC is strong post-COVID, but Nigeria still lacks a dedicated *National Institute for Occupational Health*. Establishing one would mirror NIOH and improve data on workplace

³⁵ ibid



diseases. South Africa's Mine Health and Safety Act, No. 29 of 1996 is stricter than the general OHS Act. It mandates safety representatives, health and safety committees, and tripartite councils.

8.0 Conclusion

The legal and institutional frameworks for public and occupational health in Nigeria, Kenya and South Africa have evolved from colonial-era laws to more comprehensive, rights-based statutes. Nigeria's NHA 2014, NCDC Act 2018 and ECA 2010, Kenya's Health Act 2017, OSH Act 2007 and WIBA 2007, and South Africa's NHA 2003, OHS Act 1993 and COIDA 1993 all established the foundation for disease control and worker protection. However, implementation across the three countries remains weak due to fragmentation, inadequate funding, and limited coverage of the informal sector where most workers are employed.

Changing dynamics such as urbanization, climate change, pandemics, gig work and the growth of the informal economy have exposed major gaps. Public health emergencies like COVID-19, Lassa fever and cholera revealed weaknesses in surveillance and coordination, while occupational injuries, chemical exposure and psychosocial hazards showed that existing OSH laws are outdated and poorly enforced. In all three jurisdictions, the ratio of inspectors to workplaces is low, penalties are not deterrent, and inter-agency collaboration remains weak, leaving large populations vulnerable.

9.0 Recommendations

Legal and Policy Reforms

All three countries should harmonize and modernize their laws to reflect current realities. Nigeria should urgently pass the Occupational Safety and Health Bill to replace the 2004 Factories Act and extend coverage to the informal sector. Kenya should strengthen alignment between national and county health laws under the Health Act 2017. South Africa should fast-track full implementation of the NHI Act 2023. All three should domesticate ILO Conventions 155 and 187 and develop sector-specific regulations for mining, construction, agriculture and gig work to address emerging hazards.

Institutional Strengthening, Funding and Data Systems

Governments must increase budgetary allocation to health and labour sectors in line with the Abuja Declaration target of 15%. Inspectorates should be adequately staffed, digitized and empowered to conduct risk-based audits. Nigeria should establish a National Institute for Occupational Health similar to South Africa's NIOH. Kenya and Nigeria should deepen integration of DHIS2 and SORMAS with occupational disease registries. Social protection agencies NSITF Nigeria, Director of WIB Kenya, and Compensation Fund South Africa should expand coverage to informal associations, SACCOs and SMEs through subsidized contributions.

Inclusive Governance, Prevention and Multi-Sectoral Action

A preventive and inclusive approach should be adopted. This includes mandatory workplace OSH committees, health and safety training, and public education using the One Health model. Environmental health must be prioritized through strict enforcement of NESREA Nigeria, NEMA Kenya and NEMA South Africa in polluted communities. Employers should be incentivized for compliance while penalties are reviewed upward to deter violations. Finally, civil society, trade unions and the private sector must be engaged in policy-making to ensure that public and occupational health governance is equitable, resilient, and responsive to climate change and future pandemics.